SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
Insurance Benefits

Certification Regarding Tobacco Use

SUBSCRIBER NAME:	SUBSCRIBER BIN OR SSN:	EMPLOYER GROUP NUMBER:

NON-TOBACCO-USER PREMIUM

- ❑ I certify that I am eligible for the Non-Tobacco-User Premium by **checking this box** and returning this form to PEBA Insurance Benefits. By checking this box, I certify the truth and understanding of the following:
  - ❖ I certify that all persons covered by my health insurance through PEBA Insurance Benefits (including myself and any dependents) are not currently using, and have not used, any tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last 6 months.
  - ❖ I certify that if this information changes at any time in the future, while I have health insurance coverage through PEBA Insurance Benefits, I will notify PEBA Insurance Benefits of such change within 30 days through completion and re-submission of this form.
  - ❖ I certify that this information is true and correct to the best of my knowledge.
  - ❖ **I understand that if it is determined that I (or any of my covered dependents) have used tobacco products within the last 6 months or if I (or any of my covered dependents) start using tobacco products after the date of this certification without notifying PEBA Insurance Benefits, I will be subject to penalties including, but not limited to, payment of the premium difference since last certification, plus a 10% penalty and elimination of the tobacco user's out-of-pocket maximum for the current year and following year.**
  - ❖ I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the Tobacco-User Premium I have already paid.

TOBACCO-USER PREMIUM

- ❑ I acknowledge that I will pay the Tobacco-User Premium by **checking this box**. I declare that one or more persons covered by my health insurance through PEBA Insurance Benefits uses tobacco products in some form or that I choose not to disclose my status as it relates to tobacco use. I understand that by checking this box I will pay the Tobacco-User Premium.

_____ _____
SUBSCRIBER SIGNATURE DATE

_____ _____
BENEFITS ADMINISTRATOR SIGNATURE DATE

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THE AGENCY RESERVES THE RIGHT TO REVISE THE TERMS AND CONDITIONS OF THIS DOCUMENT IN WHOLE OR IN PART AT ANY TIME. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

 If you have any questions, please call Customer Service at 803-734-0678 or toll-free at 888-260-9430.

Return this completed form to PEBA Insurance Benefits, PO Box 11661, Columbia, SC 29211.